

Opening Statement of the Honorable Fred Upton
Subcommittee on Health
Hearing on “Keeping the Promise: How Better Managing Medicare Can Protect Seniors’
Benefits and Save Them Money”
March 4, 2014

(As Prepared for Delivery)

Today we examine the operating structure of Medicare – the relationships between the Medicare program and its contractors that are essential to ensure that the benefits and care our seniors depend on are delivered as intended.

As we have warned many times, the financial sustainability of Medicare is under serious threat, putting the access to and quality of care for current and future seniors in jeopardy. The Medicare Part A trust fund is expected to run out as soon as 2017, while the cost of the entire Medicare program is projected to reach a trillion dollars each year by the end of the decade.

This is a problem that requires more than better program management or combating waste, fraud, and abuse, but that does not mean that the important work of improving program effectiveness should be neglected. We must safeguard every Medicare dollar to keep the promise of quality health care to our nation’s seniors and future generations.

The Government Accountability Office repeatedly has warned that the Medicare and Medicaid programs face a particularly high vulnerability to fraud, due to their “size, scope, and complexity.” The Medicare program receives 4.5 million claims per day from 1 million providers, who supply an extraordinarily wide range of services that must by law be reimbursed within 30 days. The program therefore faces a substantial challenge to ensure that its funds are used appropriately.

Medicare is implemented and audited by a patchwork of different contractors, established by succeeding waves of legislation over the past half-century. Its approach is loosely known as “pay-and-chase”: one set of contractors fulfills claims, while others are then charged with following up to retrospectively investigate and identify payments that have been inappropriately made.

In processing millions of claims, a tremendous amount of data gets collected, but information regarding payments is often fragmentary and scattered amongst separate organizations. As a result, oversight is poorly coordinated. The effectiveness of CMS contractors could be greatly enhanced by cooperation, but this is seriously impeded by federal law – sometimes with good reason, but in too many instances this is not the case.

The purpose of this hearing is to reexamine existing arrangements and to further the discussion regarding what can be done to enhance contractor performance, accountability and efficiency. While most of this effort requires leadership and commitment from CMS, I hope that our witnesses today will take the lead in this discussion and that outside partners and friends of the Medicare program will subsequently feel encouraged to contribute their own recommendations and suggestions. This is just one small, but important step in securing the future of the Medicare program and ensuring that every taxpayer dollar spent through this program is used most effectively. Let’s work together to keep the promise to our seniors.

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